STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005366	A. BUILDING _____ B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HOME CARE	1315 DIRECTORS ROW STE 210 FORT WAYNE, IN 46808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a Home Health agency state licensure survey. Survey Dates: January 31 and February 1 and 5, 2013 Facility Number: IN005366 Medicaid Number: 100265250A Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 797 Home Health Aide Only: 16 Total: 813 Heartland Home Care is in compliance with the Indiana rules for home health agencies 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN February 5, 2013	N 000		